# Community 2015-2016 Insurance Information Form & Vaccine Administration Record

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

**Information about the person to receive vaccine** (please print): *Required Fields

| Name: (Last, First, MI)* | Date of birth: * _____ ____ _____ Month Day Year | Age* | Sex: (Circle)* Male Female |
|---|---|---|---|
| Street Address:* | | | |
| City:* | State: * | Zip:* | Phone:* ( ) |

**Insurance Information:** *Include the whole member ID number and any letters that are part of that number*

| Name of Insurance Company:* | Member ID Number:* | Group ID Number: (if available) |
|---|---|---|

**If person getting vaccinated is not the subscriber, please complete the following:**

| Subscriber's Name: (Last, First, MI)* | Subscriber's Date of Birth: * _____ ____ _____ Month Day Year | Sex: (Circle)* Male Female |
|---|---|---|
| Subscriber's Street Address:* (If different from address above) | | |
| City:* | State:* | Zip: * | Phone:* ( ) |
| Patient Relationship to Subscriber: (Circle)* Spouse Child Other | | |

**For children 18 years of age and younger:**

Is Vaccine for Children (VFC) Program eligible:
- ☐ Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)
- ☐ Does not have health insurance
- ☐ Is American Indian (Native American) or Alaska Native

Is not VFC-eligible:
- ☐ Has health insurance and is not American Indian (Native American) or Alaska Native

**I give permission for my insurance company to be billed.**

X _____ Date: _____

*(Signature of patient, parent or legal guardian)*

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**For Clinic/Office Use Only:**

**Signature of Vaccine Administrator:** _____

| Date of Service | Vax Type | Vaccine Mfgr | Lot No | Exp Date | Dose (mL) | State Supplied | Preserv Free | Injection Route (Circle) | Injection Site (Circle) | Date On VIS | Date VIS Given |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | IIV4 | | | | 0.5 | Yes | Yes No | IM | R Arm L Arm | 8/7/15 | 9/9/15 |
| | LAIV4 | Med-Immune | | | 0.2 | Yes | Yes | Intranasal | NA | 8/7/15 | 9/9/15 |

Provider Name: Newton Health and Human Services Department MDPH Provider PIN#: 11223

*Provider Address: 1000 Commonwealth Ave. Newton, MA 02459*